What's Changing in 2009*

Please see the comparison chart and plan documents for details on the changes below.

CAPE/Blue Shield Lite and Classic

- New added coverage for immunizations and periodic health exams.
- Reduced generic prescription drug copays: $5 copay for generic and $10 copay for 90-day generic mail order.
- Eye exams now covered for non-MES providers.

ALADS/Blue Cross Prudent Buyer and CaliforniaCare

- Increase in lifetime maximum to $5,000,000 for Prudent Buyer plan.
- Change in mental health provider to Holman Professional Counseling Centers (HPCC), and various changes to coverage.

Fire Fighters Local 1014

- Coinsurance increases to 90% for in-network.
- Increase in lifetime maximum to $4,000,000.
- Increase in LASIK eye benefit to 80% with a maximum of $1,500 per eye.
- Hearing aids covered for children thru age 19 to a maximum of $1,000 per ear every three years.
- Coverage for shingles vaccination and enhanced vision care/VSP benefits.

Other Changes

- Optional group term life and dependent term life insurance rates dropped 10%.

** Benefit plans and premium rate changes are subject to final approval by the Board of Supervisors.*

Dental Plans Comparison Chart

	SAFEGUARD	DELTACARE	DELTA DENTAL PLAN			ALADS/BLUE CROSS PREMIER PLANS*	
			DELTA PREFERRED OPTION (DPO)	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Type of Plan	An HMO-style dental plan	An HMO-style dental plan	A dental plan that offers two provider networks and out-of-network benefits			An indemnity plan with PPO incentive, offering in- and out-of network benefits	
Annual Deductible	None	None	None	$50/person; $150/family	$50/person; $150/family	$50/person; $150/family	
Annual Maximum Benefit	None	None	$1,500/person (all care must be from DPO network)	$1,200/person	$1,200/person	$1,500/person	
PREVENTIVE CARE							
Cleaning	100% (two every 12 months)	100% (two every 12 months)	100% (two/calendar year)	80% (no deductible for first two/calendar year	80% of R&C (no deductible for first two/calendar year)	100%; no deductible (two in 12 months)	100% of R&C; no deductible (two in 12 months)
Exam	100%	100%	100% (two/calendar year)	80% (two/calendar year)	80% of R&C (two/calendar year)	100%; no deductible	100% of R&C; no deductible
Full Mouth X-Rays	100% (one every 24 months)	100% (one every 24 months)	100% (one every five years)	80% (one every five year)	80% of R&C (one every five year)	100%; no deductible (one every 36 months)	100% of R&C; no deductible (one every 36 months)
BASIC SERVICES							
Emergency Treatment	$5 copay	$5 copay	100%	80%	80% of R&C	Covered as regular treatment	Covered as regular treatment
Extractions	100%	100%	85%	80%	80% of R&C	90%	85% of R&C
Fillings	100%	100%	85%	80%	80% of R&C	90%	85% of R&C
General Anesthesia	$30 copay for medically necessary extractions only	$30 copay for medically necessary extractions only	85% for oral surgery only	80% for oral surgery only	80% of R&C for oral surgery only	90%	85% of R&C
Gingivectomy	$55 copay/quadrant	$55 copay/quadrant	85%	80%	80% of R&C	60%	50% of R&C
Root Canals	$45 copay/canal	$45 copay/canal	85%	80%	80% of R&C	90%	85% of R&C
MAJOR SERVICES							
Bridges	$60 copay/unit	$60 copay/unit	50% (once every five years)	50% (once every five years)	50% of R&C (once every five years)	60% (once every five years)	50% of R&C (once every five years)
Crowns	$60 copay/crown	$60 copay/crown	85% (once every five years)	50% (once every five years)	50% of R&C (once every five years)	60% (once every five years)	50% of R&C (once every five years)
Dentures	$70 copay/denture	$70 copay/denture	50% (once every five years)	50% (once every five years)	50% of R&C (once every five years)	60% (once every five years)	50% of R&C (once every five years)
Orthodontia	$1,000 copay + $150 start-up fees	$1,150 copay + $350 start-up fees	Not covered	Not covered	Not covered	50% of R&C up to $1,500 lifetime max.	
TMJ	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

** The ALADS Blue Cross CaliforniaCare and Prudent Buyer Premier Plans provide the dental coverage listed on this chart.*

Contact Information

Contact	Phone Number	Web Site
COUNTY DEPARTMENT OF HUMAN RESOURCES		
Benefits Hotline	213-388-9982	N/A
Web Site	N/A	http://dhr.lacounty.info/
BENEFITS SYSTEM		
Web Enrollment	N/A	www.buckhrsolutions.com/countyla
Telephone Enrollment	888-822-0487	N/A
Fax	310-788-8775	N/A
MEDICAL		
CIGNA	800-842-6635	cigna.com
Kaiser Permanente	800-464-4000	my.kp.org/ca/countyofla
ALADS/Anthem Blue Cross (HMO)	800-842-6635	anthem.com/ca
ALADS/Anthem Blue Cross (PPO)	800-842-6635	anthem.com/ca
CAPE/Blue Shield	800-487-3092	blueshieldca.com
Fire Fighters Local 1014	800-660-1014	local1014medical.org
DENTAL		
SafeGuard	800-880-1800	www.safeguard.net
DeltaCare	800-422-4234	deltadental.com
Delta Dental	888-335-8227	deltadental.com
ALADS/Blue Cross (dental)	800-842-6635	anthem.com/ca
FLEXIBLE SPENDING ACCOUNTS		
Administrator (Ceridian)	866-300-2303	www.buckhrsolutions.com/countyla
Fax	888-367-3305	N/A
LIFE AND AD&D		
CIGNA Life	800-842-6635	cigna.com

Annual Deductible
Annual Out-of-Pocket Maximum
Lifetime Maximum Benefit
PREVENTIVE CARE
Immunizations
Periodic Health Evaluations
Vision Care
MEDICALLY NECESSARY CARE
Ambulance
Doctor Office Visit
Emergency Room
Hospital Care
Maternity
Surgery
X-Ray & Lab Tests
Prescription Drugs
MENTAL HEALTH CARE
Mental Health Outpatient
Mental Health Inpatient
OTHER PLAN BENEFITS
Chiropractic Care
Home Health Care
Hospice Care
Physical Therapy
Skilled Nursing Facility

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2009 Annual Benefits Medical and Dental Plans Comparison Chart

Medical Plans Comparison Chart — County-Sponsored Plans

KAISER	CIGNA NETWORK HMO	CIGNA NETWORK POS	
		IN-NETWORK	OUT-OF-NETWORK
None	None	None	$500/person $1,000/family
$1,500/person $3,000/family	1 party-$1,000 2 party-$2,000 Family-$3,000	1 party-$1,000 2 party-$2,000 Family-$3,000	None
Unlimited	Unlimited	Unlimited medical; $25,000 substance abuse lifetime max	Unlimited medical; $25,000 substance abuse lifetime max
PREVENTIVE CARE			
No charge for most common immunizations	$10 copay/visit	$10 copay/visit	60% of R&C after deductible
$10 copay/visit	$10 copay/visit	$10 copay/visit	60% of R&C after deductible
$10 copay for eye exam at Kaiser facility (glasses not covered)	$10 copay for eye exam at contracted facility (one non-medical refraction/12 months) $10 copay for glasses (1 pair/12 months)	Not covered	Not covered
MEDICALLY NECESSARY CARE			
100% if medically necessary	100% when ordered/approved by CIGNA	100% when ordered/approved by CIGNA	Paid as in-network if true emergency, otherwise 60% of R&C after deductible
$10 copay/visit; no charge pediatric visit to age 5 except routine physical exam	$10 copay/visit	$10 copay/visit	60% of R&C after deductible
$50 copay; waived if admitted	$50 copay (waived if admitted)	$50 copay/visit (waived if admitted)	60% of R&C after deductible (precertification required for non-emergency hospitalization or $500 penalty and 50% reduction in benefits)
100%	100%	$50 copay/day; $200 copay annual max	60% of R&C after deductible and after $1,000 fee/admission (precertification required for non-emergency hospitalization or $500 penalty and 50% reduction in benefits)
$10 copay for visit to office to confirm pregnancy; no charge thereafter	$10 copay for visit to office to confirm pregnancy, no charge thereafter	Outpatient: $10 copay for visit to confirm pregnancy, no charge thereafter	60% of R&C after deductible
Inpatient: No charge Outpatient: $10 copay/visit	Inpatient: 100% Outpatient: $50 copay	Inpatient: 100% after $50 copay ($200 out-of-pocket max/year) Outpatient: $50 copay	60% of R&C after deductible (precertification required for non-emergency hospitalization or $500 penalty and 50% reduction in benefits)
100% for services at Kaiser facility	100% at a contracted provider	100%	60% of R&C after deductible
$5 copay for up to a 100-day supply of each medication prescribed by Kaiser physician or by any dentist & filled at Kaiser pharmacy. Sexual dysfunction drugs: 50% (limitations apply); $20 copay for brand name	Network pharmacy (30-day supply): Generic $5 copay; Brand $20 copay Mail order (90-day supply): Generic $10 copay; Brand $40 copay	Network pharmacy (30-day supply): Generic $5 copay; Brand $20 copay Mail order (90-day supply): Generic $10 copay; Brand $40 copay	60% of R&C after deductible; mail order not covered
MENTAL HEALTH CARE			
Parity diagnosis: same as doctor office visit copay (unlimited visits) Non-parity diagnosis: $10 copay (up to 20 visits, additional visits not covered)	$10 copay/visit (up to 20 visits/calendar year); $10 copay/visit (up to 20 visits/calendar year) substance abuse detox. only	Visits 1-20: $15 copay; Visits 21-30: $25 copay (substance abuse up to 30 visits or $1,000/calendar year)	50% of R&C after deductible
		Up to 30 visits/calendar year or 60 days/lifetime mental health max combined for in- and out-of-network care Substance abuse: $25,000 combined lifetime max for inpatient/outpatient and in- and out-of-network	
Parity diagnosis: 100% unlimited days Non-parity diagnosis: 100% (up to 45 days maximum/calendar year)	100% (up to 60 days/calendar year; additional visits not covered) substance abuse detox. only – no charge (up to 30 days/calendar year)	$50 copay/day for mental health (substance abuse: up to 30 days or $10,000/calendar year)	60% of R&C after deductible
		Up to 30 days/calendar year or 40-days/lifetime mental health max combined for in- and out-of-network care Substance abuse: $25,000 combined lifetime max. for inpatient/outpatient and in- and out-of-network	
OTHER PLAN BENEFITS			
Not covered	Not covered	Not covered	60% of R&C after deductible if medically necessary (up to 25 visits/calendar year)
100% if within Kaiser service area (up to 2 hrs/visit; 3 visits/day; 100 visits/calendar year)	100% (approved medical provider only)	100% (up to 100 visits/calendar year)	60% of R&C after deductible (up to 60 visits/calendar year, reduced by in-network visits)
100%	100%	100% (with in/out of network combined $10,000 max)	100% (with in/out of network combined $10,000 max)
$10 copay/visit	$10 copay/visit	$10 copay/visit	60% of R&C after deductible (up to 60 days/condition)
100% (up to 100 days/benefit period)	100% when authorized by PCP (up to 100 days/calendar year)	$50 copay/day, $200 out-of-pocket max/year (up to 100 days/calendar year)	60% of R&C after deductible for semiprivate room rate, plus $1,000 fee/admission (up to 60 days/calendar year)

	CAPE/BLUE SHIELD LITE POS PLAN			CAPE/BLUE SHIELD CH	
	HMO	IN-NETWORK	OUT-OF-NETWORK	HMO	IN-NET
Annual Deductible	None	$500/person; $1,000/family		None	
Annual Out-Of-Pocket Maximum	$2,000/person; $4,000/family	After deductible, $4,000/person; $8,000/family	After deductible, $6,000/person; $12,000/family	$2,000/person; $4,000/family	After ded $4,000/ $8,000/
		(combined in- and out-of-network)			
Lifetime Maximum Benefit	Unlimited	$4,000,000		Unlimited	
PREVENTIVE CARE					
Immunizations	100%	100% after $25 copay (no deductible)	60% of allowable amount (after deductible)	100%	100% after $20 cop
Periodic Health Evaluations	100% (including well woman exam, pap smear and mammography)	100% after $25 copay (no deductible)	60% of allowable amount (after deductible)	100% (including well woman exam, pap smear and mammography)	100% after $20 cop
Vision Care	100% (up to age 18 for screenings only); one annual eye exam after $10 copay at MES providers only	*MES Provider* One annual eye eam after $10 copay *Non MES Provider* Ophthalmologist exams: up to $60 reimbursement Optometrist exams: up to $50 reimbursement	*Non MES Provider* Ophthalmologist exams: up to $60 reimbursement Optometrist exams: up to $50 reimbursement	100% (up to age 18 for screenings only); one annual eye exam after $10 copay at MES providers only	*MES Pr* One annual eye ea *Non MES* Ophthalmolo up to $60 rei Optometrist exams: up
MEDICALLY NECESSARY CARE					
Ambulance	100% after $50 copay	80% after deductible	80% of allowable amount (after deductible)	100% after $50 copay	90% after
Doctor Office Visit	100% after $10 copay	100% after $25 copay (for consultation only, not subject to deductible)	60% of allowable amount (after deductible)	100% after $10 copay	100% after (for consult not subject to
Emergency Room	100% after $50 copay (waived if admitted)	100% after $50 copay (waived if admitted)	100% after $50 copay (waived if admitted)	100% after $50 copay (waived if admitted)	100% after (waived if
Hospital Care	100%	80% after deductible	60% of allowable amount (after deductible), up to $360 carrier max/day	100%	90% after
Maternity	100%	100% after $25 copay/visit (for consultation only, not subject to deductible)	60% of allowable amount (after deductible)	100%	100% after $2 (for consult not subject to
Surgery	100% (outpatient $75 copay)	80% after deductible	60% of allowable amount (after deductible) Outpatient: up to $360 carrier max/day	100% (outpatient $50 copay)	90% after
X-Ray & Lab Tests	100%	80% after deductible	60% of allowable amount (after deductible)	100%	90% after
Prescription Drugs	$5 generic; $15 brand; $30 non-formulary Mail order (90-day supply): $10 generic; $30 brand; $60 non-formulary	$5 generic; $15 brand; $30 non-formulary Mail order (90-day supply): $10 generic; $30 brand; $60 non-formulary	Covered for emergencies only — copay applies	$5 generic; $15 brand; $30 non-formulary Mail order (90-day supply): $10 generic; $30 brand; $60 non-formulary	$5 generic; $15 brand Mail order (90-day su $30 brand; $60
	(non-formulary must be preapproved by Blue Shield)			(non-formulary must be preapproved by Blue Shield)	
MENTAL HEALTH CARE					
Mental Health Outpatient	Non-severe psychiatric care: $10 copay for initial visit; $50 copay/visit thereafter (up to 20 combined visits/calendar year) Severe mental illness: $10 copay/visit	Non-severe psychiatric care: $10 copay for initial visit; $50 copay/visit thereafter (up to 20 combined visits/calendar year) Severe mental illness: $10 copay/visit	Non-severe psychiatric care: 50% after deductible (up to 20 combined visits/calendar year) Severe mental illness: 60% of allowable amount (after deductible)	Non-severe psychiatric care: $10 copay for initial visit; $50 copay/visit thereafter (up to 20 combined visits/calendar year) Severe mental illness: $10 copay/visit	Non-severe psychiatri initial visit; $50 cop (up to 20 combined v Severe mental illnes
	Provided by United Behavioral Health. Must be arranged through MHSA			Provided by United Behavioral Health. Must be arranged throug	
Mental Health Inpatient	100%	100%	60% of allowable amount (after deductible), up to $360 carrier max/day	100%	100
	Provided by United Behavioral Health. Must be arranged through MHSA			Provided by United Behavioral Health. Must be arranged throug	
OTHER PLAN BENEFITS					
Chiropractic Care	100% after $15 copay	100% after $15 copay	Not covered	100% after $10 copay	100% after
	Includes acupuncture; up to 30 combined visits/calender year (based on medical necessity); Provided through American Specialty Health Plans			Includes acupuncture; up to 40 combined visits/calender year (based on Provided through American Specialty Health Plans	
Home Health Care	100% after $10 copay	80% after deductible	60% of allowable amount (after deductible)	100% after $10 copay	90% after
	(up to 100 combined visits/calendar year)			(up to 100 combined vis	
Hospice Care	100% when provided by authorized hospice agency		Not covered unless authorized by Blue Shield	100% when provided by authorized hospice agency	
Physical Therapy	100% after $10 copay	80% after deductible	60% of allowable amount (after deductible)	100% after $10 copay	90% after
Skilled Nursing Facility	100%	80% after deductible	60% of allowable amount (after deductible)	100%	90% after
	(up to 100 combined days/calendar year)			(up to 100 combined da	

Indicates Plan Changes

This is not an official summary plan description (SPD) or official plan document. If you need a copy of an official plan document, contact the plan's Customer Service department directly. If there is a difference between what you read in this comparison chart and what you read in an official plan document, the official plan document will rule.

hart—Union Sponsored Plans

LASSIC POS PLAN		ALADS/ANTHEM BLUE CROSS PRUDENT BUYER BASIC AND PREMIER PLANS*		ALADS/ANTHEM BLUE CROSS CALIFORNIACARE BASIC AND PREMIER PLANS*	FIRE FIGHTERS LOCAL 1014 MEDICAL PLAN
WORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK		
$300/person; $600/family		$200/person; $600/family	$200/person; $600/family	None	$200/person; $600/family
luctible, person; /family	After deductible, $6,000/person; $12,000/family	$450/person (after deductible)	$6,000/person (after deductible)	$500/person; $1,500/family (excludes infertility treatment)	After deductible, In-Network: $1,000/person $1,000/family Out-of-Network: $1,500/person $1,500/family
(combined in- and out-of-network)					
$4,000,000		$5,000,000		Unlimited	$4,000,000
					PREVENTIVE CARE
pay (no deductible)	60% of allowable amount (after deductible)	90% after deductible (children up to age 7 only)	70% after deductible (children up to age 7 only)	$5 copay	100% through age 19; $3,000 lifetime max
pay (no deductible)	60% of allowable amount (after deductible)	Up to age 7: 90% after deductible; age 7 and over: $25 copay/visit ($250 max/calendar year)	Up to age 7: 70% after deductible; age 7 and over: not covered	$5 copay/visit	No deductible; routine exams and screenings (up to $550 combined annual max); well woman, well man, well child benefits also available
rovider m after $10 copay Provider gist exams: mbursement to $50 reimbursement	*Non MES Provider* Ophthalmologist exams: up to $60 reimbursement Optometrist exams: up to $50 reimbursement	Exams, lenses, frames or contacts covered through VSP; 90% after deductible up to $1,500/eye for radial keratotomy	Exams, lenses, frames or contacts covered through VSP; 70% after deductible up to $1,500/eye for radial keratotomy	Exams, lenses, frames or contacts covered through VSP	Exams, lenses, frames or contacts covered through VSP. See medical plan SPD for details. LASIK benefit 80% after deductible; up to $1,500/eye
					MEDICALLY NECESSARY CARE
deductible	90% of allowable amount (after deductible)	80% after deductible	80% after deductible	100%	90% after deductible**
$20 copay ation only, o deductible)	60% of allowable amount (after deductible)	90% after deductible	70% after deductible	$5 copay/visit	90% after deductible**
$50 copay admitted)	100% after $50 copay (waived if admitted)	90% after deductible	70% after deductible	No charge if admitted as inpatient; $25 copay/visit if outpatient	$50 copay/visit (waived if admitted)
deductible	60% of allowable amount (after deductible), up to $420 carrier max/day	90% after deductible (precertification required or coverage reduced by 20%)	70% after deductible (precertification required or coverage reduced by 20%)	100%	90% after deductible; preauthorization required**
20 copay/visit ation only, o deductible)	60% of allowable amount (after deductible)	90% after deductible (precertification required or coverage reduced by 20%)	70% after deductible (precertification required or coverage reduced by 20%)	$5 copay/visit	90% after deductible**
deductible	60% of allowable amount (after deductible) Outpatient: up to $420 carrier max/day	90% after deductible (precertification required or coverage reduced by 20%)	70% after deductible (precertification required or coverage reduced by 20%)	100%	90% after deductible**
deductible	60% of allowable amount (after deductible)	90% after deductible	70% after deductible	100%	90% after deductible (other than periodic health exams)**
l; $30 non-formulary upply): $10 generic; non-formulary	Covered for emergencies only— copay applies	$5 copay for generic $10 copay for brand Mail order (90-day supply): $5 copay for generic $5 copay for brand	$5 copay for generic $10 copay for brand (plus 50% of covered expenses)	$5 copay for generic $10 copay for brand Mail order (90-day supply): $5 copay for generic $5 copay for brand	$10 copay for generic; $20 copay for brand (when generic unavailable); $30 copay for brand plus cost above generic allowance (when generic available)
					MENTAL HEALTH CARE
c care: $10 copay for pay/visit thereafter visits/calendar year) ss: $10 copay/visit	Non-severe psychiatric care: 50% after deductible (up to 20 combined visits/ calendar year) Severe mental illness: 60% of allowable amount (after deductible)	$20 copay/visit (up to 50 combined visits/calendar year) parity diagnosis treated as any other illness	$25 copay/visit (up to 50 combined visits/calendar year) parity diagnosis treated as any other illness	$20 copay/visit (up to 50 combined visits/calendar year) parity diagnosis treated as any other illness	Assessment: 1-3 visits/6 months: no copay Individual sessions: • In-Network: 1-6 visits; no copay 7-50 visits; $15 copay • Out-of-Network: 1-25 visits; $20 copay Severe mental health (unl. visits): • In-Net- work:$15 copay • Out-of-Network: $20 copay Provided by MHN
gh MHSA		*Provided by The Holman Group*			
0%	60% of allowable amount (after deductible), up to $420 carrier max/day	20% copay (up to 30 days/calendar year) parity diagnosis treated as any other illness	Covered for emergencies only— 20% copay applies parity diagnosis treated as any other illness	No charge (up to 50 days/calendar year) parity diagnosis treated as any other illness	Combined maximum of 30 days/calendar year mental health and substance abuse; severe mental health: unlimited days • In-Network: $200 copay • Out-of-Network: 80% Provided by MHN
gh MHSA		*Provided by The Holman Group*			
					OTHER PLAN BENEFITS
$10 copay medical necessity);	Not covered	90% after deductible	70% after deductible	$5 copay (up to 20 visits/calendar year)	90% after deductible** (up to 30 total visits/calendar year; combined limit for chiropractic and acupuncture)
deductible sits/calendar year)	60% of allowable amount (after deductible)	90% after deductible	70% after deductible	$5 copay (up to 4 hrs/day max)	90% after deductible (maximum 100 visits/ calendar year)
	Not covered unless authorized by Blue Shield	80% after deductible	80% after deductible	100%	90% after deductible ($20,000 lifetime max)
deductible	60% of allowable amount (after deductible)	90% after deductible	70% after deductible	$5 copay (up to 60 days/illness or injury)	90% after deductible (30 visits/calendar year)
deductible ays/calendar year)	60% of allowable amount (after deductible)	90% after deductible	70% after deductible	100% (up to 100 days/calendar year)	90% after deductible**

* The ALADS Blue Cross CaliforniaCare and Prudent Buyer Premier Plans offer full dental coverage; the Basic plans do not.

** For out-of-network care, the plan pays 70% after deductible. Refer to the Local 1014 Medical Plan Summary Plan Description (SPD) for a complete description of plan benefits.